

# The EBD Buzz

A quarterly benefit publication by the DFA Employee Benefits Division for  
Arkansas State and Public School Employees and Retirees



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1st Quarter 2005

Dear State and Public School Employees and Retirees,

I am pleased to provide you with the very first issue of the EBD Buzz. During the recent open enrollment periods this fall, EBD conducted the largest ever effort in going onsite to schools and state agencies, as well as holding town meetings to provide information directly to you. But even with that effort, I feel that we only touched a very small percentage of you. That is the catalyst for providing this newsletter. It's a consolidated and efficient communication tool in lieu of a flurry of individual letters on each topic.

It is important to know more about your insurance benefits, how to access necessary services, as well as upcoming benefit changes. I hope this newsletter will provide each of you with that information and that it will be meaningful to you. Please contact me if you have a topic of particular interest you would like to have explained in this newsletter.

Sincerely,

**Sharon Dickerson**

EBD Executive Director



## Where Does the Money Go?

ARKANSAS STATE EMPLOYEES HEALTH PLAN	
Plan Year 2004 (12 months) 01/01/04 to 12/31/04	
Income (Premiums, State Agency Contributions, Rebates, Vendor Penalties, FICA Savings)	218,354,483
<b>Total Income</b>	<b>218,354,483</b>
Expenses:	
Healthcare	154,125,101
Pharmacy	42,454,896
Life Insurance	1,688,193
<b>Total Expenses</b>	<b>198,268,190</b>
<b>Subtotal</b>	<b>20,086,293</b>
**Premium Subsidy	12,000,000
<b>Ending Balance 12/31/04</b>	<b>8,086,293</b>
**\$12,000,000 will be used to subsidize premiums for Plan Year 2005	
<b>Member Enrollment</b>	
Active Employees	25,402
Retirees	6,848
COBRA Participants	156
<b>Total</b>	<b>32,406</b>

PUBLIC SCHOOL EMPLOYEES HEALTH PLAN	
Plan Year 2004 (12 months) 10/01/03 to 09/30/04	
Income (Premiums, School District Contributions, Rebates, Vendor Penalties)	200,812,598
<b>Total Income</b>	<b>200,812,598</b>
Expenses:	
Healthcare	150,018,218
Pharmacy	45,201,616
Life Insurance	303,974
<b>Total Expenses</b>	<b>195,523,808</b>
<b>Ending Balance 9/30/04</b>	<b>5,288,790</b>
<b>Member Enrollment</b>	
Active Employees	37,692
Retirees	5,416
COBRA Participants	740
<b>Total</b>	<b>43,848</b>

*This document shall stand as a Summary of Material Modification (SMM) to the Summary Plan Description (SPD) governing the Arkansas State and Public School Health Plans.*

# State and School Drug Formulary Under Review

The Drug Utilization Review subcommittee of the State and Public School Health and Life Insurance Board (the Board), the UAMS College of Pharmacy consultants and the Pharmacy Benefits Manager (NMHC Rx) will be reviewing and evaluating all the drug classes in 2005. This group of individuals consists of physicians and pharmacists that determine if a drug is the most appropriate drug to be placed on the formulary. If so, it will be recommended to the Board. With Board approval, the drug will be placed on the formulary. The subcommittee also evaluates the current formulary drugs to determine if they will remain, be removed, or moved to 3rd tier (\$50 copay), with Board approval.

This group of individuals met recently and reviewed several drug classes. Their recommendations were approved by the Board and the following changes in formulary medication will be effective April 1, 2005:

- **Prescription antihistamines will now be 3rd tier.** Zyrtec will move to the 3rd tier (\$50 copay). Rationale: Clinically there is not a substantial difference between Claritin and other drugs in this class. Claritin is available Over the Counter (OTC). Generic Claritin (loratadine) can be purchased OTC for \$8-\$10 for a 30 day supply and Claritin can be purchased for about \$22. This is a cost savings for members who require antihistamines, as the purchase of OTC medications are less than the \$25 copay.
- **Fortamet (metformin hydrochloride) extended release will not be covered at all.** Rationale: This diabetic medication is similar to other generic drugs that are now on formulary. It is a new Brand drug that has the same action of the generic drugs.
- **Riomet- will be added to 2nd tier (\$25 copay).** Rationale: This is a new liquid diabetic drug.
- **Kineret, (for rheumatoid arthritis) will require prior authorization (PA).** Rationale: This drug costs about \$4,000 per prescription. It has been shown to be ineffective if the patient has not responded to infliximab or etanercept. If a patient has had the other two drugs with no response, he would not respond to this drug either.
- **All Cox II inhibitors will be moved to 3rd tier (\$50 copay):** Celebrex, Bextra and Mobic. Rationale: As you

know, Vioxx was removed from the market and there has been talk from the FDA of removing Celebrex. Public health concerns exist for this class of drugs and they have not been proven to be more effective than the generic non-steroidal anti-inflammatory medications. Though Mobic is not a Cox II inhibitor, its effects are similar.

- **Tricor will move to 3rd tier (\$50 copay).** Rationale: Generics are available in this class and there are also brands available on 2nd tier (\$25 copay) for lowering cholesterol.
- **Singulair will be 2nd tier only for asthmatics under this condition:** The member should be taking both an inhaled corticoid steroid and a beta agonist; however if the member's physician documents that an asthmatic's condition is stable without inhaled steroids or the beta agonist, the drug will be available at a \$25 copay with Prior Authorization (PA). Otherwise, this drug is not covered at all.

## Other important information:

- **Prescriptions will no longer be available in 34 day, 68 day and 102 day supply increments.** Effective April 1, 2005, prescriptions will only be available in 31 day, 62 day and 93 day increments. Rationale: This reduction will save the plan about \$1.2 million annually which helps slow the increase of pharmacy costs to the health plan as a whole.
- **When a drug has a generic available the Brand drug will immediately go to the 3rd tier (\$50 copay) and the plan member can obtain the generic at the 1st tier (\$10 copay).** EBD will not send individual member letters when drugs become generic. There may be some situations when a drug is not covered at all - then the plan member will not be able to obtain the generic for the \$10 copay or the Brand at the \$50 copay, but must pay the entire cost of the drug. The exception to this is generic Neurontin (gabapentin). Gabapentin will be available at the first tier copayment of \$10 only to those with the approved diagnosis of seizures and postherpetic neuralgia. For other diagnoses, it will require a \$50 copayment.

**The changes described above will go into effect on April 1, 2005.** Health plan members taking the affected drugs will receive individual communications regarding the changes. If you have questions about these changes please contact the Employee Benefits Division.

# Retiree Report

## MEDICARE OPEN ENROLLMENT

The general Medicare open enrollment period is from January through March each year for a July 1st effective date. Retirees without Medicare Part B should contact the Social Security Administration at 1-800-772-1213 about obtaining Part B coverage. Medicare Part B premiums are paid monthly and may increase up to 10% for each 12 month period that the person could have had Part B but did not sign up for it (there are some special exceptions).

In order for the Employee Benefits Division (EBD) to adjust the health premium to the lower Medicare rate, EBD must receive a copy of the Medicare card as soon as it is available. If a copy of the card is received by the 15th of the month, the reduced rate will be reflected on the next Retirement Annuity payment.

## RETIREES ELIGIBLE FOR MEDICARE

Subscribers and dependents that are eligible for Medicare must have both Part A and Part B. The plan will coordinate benefits if Part B is in force. If a plan member who is eligible for Medicare **does not** have Medicare Part B, the plan will pay as though the member **does** have Medicare Part B.

## IRS Changes Definition of “Dependent” for Pre-Taxed Plan Deductions

The Internal Revenue Service (IRS) has specifically outlined changes for a qualified child that may be covered under a plan with pre-taxed deductions. The Employee Benefits Division (EBD) has adopted most of the IRS changes. In order for a dependent child to remain in a pre-taxed medical plan, dental plan, a health flexible spending account or health savings account, the following requirements must be met:

- **Relationship** - the qualifying child must have a familial relationship to the member, i.e., child, stepchild, adopted child.
- **Residency** - A qualifying child must have the same principal place of abode as the taxpayer for more than one half of the tax year. Temporary absences due to special circumstances such as illness, education, business, vacation, military service, or other similar factors are not counted as absences for purposes of residency.
- **Age** - must be between birth and age nineteen (19) or if a full-time student, must be nineteen (19) through twenty-three (23), unless the dependent is a qualified disabled dependent. Coverage for students age 24 to 27 will only be extended to the current students covered under the plan and all benefits will terminate at the end of the plan year. Any new dependent student entering the plan after February 1, 2005 must meet the age requirement or they will not be eligible for coverage.
- **Support** - The member no longer has to provide over half of the dependent-child's support, but the child must not have provided over one-half of his/her own support.

NOTE: EBD will verify student status twice a year. It is the responsibility of the primary plan member to notify EBD if the dependent is no longer a student. Insurance coverage on dependents who no longer meet age or student status requirements will be terminated:

- at the end of the month in which EBD is notified of the status change; or
- at the end of the month in which the member fails to verify via the Student Verification Form process that the dependent is no longer a student; or
- at the end of the month in which the student reaches the age of 24.

COBRA continuation will be offered to the student in all these cases. COBRA coverage may be extended to dependent students for thirty-six (36) months.

## Student Verification Forms FAQ

### 1. How many times a year does EBD mail Student Verification Forms to parents?

Twice a year – one for the Spring semester and one for the Fall semester. The health carriers no longer distribute these forms. Student Verification Forms are also generated automatically for dependents at the first of the month in which they will become 19.

### 2. May I fax the form to EBD instead of mailing it?

You can fax the form to 501-683-0983 or mail the form to EBD at the address located on the top of the form.

### 3. If my child is not a full-time student, what should I do?

Mark the Student Verification Form “No,” then mail or fax it to EBD. Notify your school business official or agency insurance representative to complete a change form to cancel coverage on that dependent and to update payroll. Failure to provide complete and accurate information may result in cancellation of coverage by the Employee Benefits Division. If the Student Verification Form is not received, coverage will be terminated.

### 4. If my child is not a full-time student but is still eligible for other reasons (disability, etc.), what do I do to continue coverage?

Contact EBD at 1-877-815-1017.

## COBRA Corner

### Did You Know?

**You are eligible to continue your health insurance through COBRA if you:**

- Terminate your employment
- Retire
- Lose your eligibility (i.e., loss of student status, divorce)

### COBRA coverage can last for up to:

- 18 Months - if you terminate employment
- 29 Months - if you become disabled at the time of, or within 60 days of electing COBRA
- 36 Months - if you lose student status, divorce, etc.

### If you elect COBRA coverage:

- You have 60 days from the time your benefits terminate to decide if you want to continue coverage through COBRA.
- Coverage is retroactively reinstated to the last day that you were covered as an active employee when you elect COBRA and make your first payment.

### Did you know that you can lose your COBRA coverage if:

- Your payment is not postmarked by the last day of the month
- You fail to pay the required premium
- You become eligible for Medicare

# EBD

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## **Tobacco Cessation Program has started!!**

The AR "Quit Now" Tobacco Cessation Program has begun and over 315 people are currently participating. This is a statewide program for Arkansas State and Public School Employees and their adult spouses covered under the State and School Employees Health Insurance plans.

As a supplement to telephonic or web-based services, individual and group sessions can be provided at multiple sites statewide: Central Pulaski County, Fayetteville/Springdale, Texarkana/Arkadelphia, Jonesboro/Paragould, Jacksonville/Cabot, & Eastern Arkansas.

To enroll anytime, please contact a Corphealth Health Educator at 1-866-378-1645 or go online to **[www.arquitnow.com](http://www.arquitnow.com)**.

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**We welcome your benefit questions & comments:**

**Call the Employee Benefits Division (EBD) during business hours at 501-682-9656 or toll free at 1-877-815-1017. You may also visit our website at [www.arkansas.gov/dfa/ebd](http://www.arkansas.gov/dfa/ebd) or send an e-mail to [AskEBD@dfa.state.ar.us](mailto:AskEBD@dfa.state.ar.us).**